Oral Hygiene

View of Cleveland Museum, Wade Park, Cleveland, Ohio. The ninety-fourth annual meeting of the American Dental Association will be held in Cleveland, September 28-October 1.

In this issue: *We Are Tired of Playing Villain*

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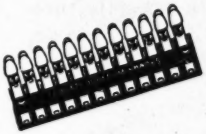

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By Mass

No. 385

Tixies on Strike

The fact that the Tixies are on strike this month perhaps will make sense only to those CORNER *customers who remember having been introduced to the little fellows in this department almost fourteen years ago, when the* CORNER *conductor wrote—*

QUIET, PLEASE, while the fingers canter about the keyboard. If this little typewriter is properly warmed up, an idea lurking amongst its gadgetty innards may become unstuck and creep out upon the paper.

The utterly noble thought, the putrescent paragraph, the deftly turned phrase, the theme which refuses to jell, the sweetly tinkling sentence, the flight of fancy that zooms to a crackup—which will it be? One never knows. One never knows.

Conceived in iniquity, or divinely bred, somewhere within the tangle of wires and wheels the miracle of birth occurs: the darling creation to be petted and fondled and made the most of, or the deformed idea, the stillborn thought.

Your fingers manipulate the keys, but inside the mechanistic mystery, the Tixies are afoot—those sagacious little typing cousins of the Pixies who have here a department of their fairy-

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land and are busy at their chosen task, superintending the accouchement of the idea, delivering the small whispy thought, wetnursing it at their tiny breasts, mothering into robust life the writing you will proudly call your own. Unless the fiends among these Little People invade the maternity ward and needle the precious embryo, poisoning on the threshhold of life what might have been a morsel of liveliness.

This afternoon, the fiends are at large down below the clatter of the keys, the intermittent clatter, the clatter that subsides so often. In the too frequent interludes the clock can be heard, ticking away forever the minutes that are needed for this writing. The fan, fighting Summer, hums a tired overtone.

The fiends are at large this afternoon, down among the wheels and wires, needling the dainty thought to death, murdering the little feller.

The nice, kind, devoted Tixies have been waging a losing battle; the fiends are in the saddle, figuratively speaking. They scamper about, and with hateful industry bring to naught the tender midwifery of their good companions. Ideas have been dying, dying, dying.

The fan hums, the clock ticks, the keys are waiting, silent. Nothing creeps out upon the paper. The joy of fortuitous fatherhood is absent. No noble thought, no deft phrase, no sweetly tinkling sentence comes as the Tixies' gift to the writing wretch...

But something stirs, wistful hope awakes, something's being shoved out upon the paper. It emerges—the poor, dead thing the fiends have slaughtered—the Idea, stark and lifeless, limp and very, very dead.

Within the machine's gadgetty innards, the good Tixies sulk despondently. In fancy, one hears the faint devilish cackle of the fiends rejoicing.

And you print the damned thing they've brought you.

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Picture of the Month

GOVERNOR James F. Byrnes signs the bill which authorizes a dental school for South Carolina. The new dental school will be a part of the State Medical College and it is hoped will be opened in the fall of 1954. Gathered around Governor Byrnes are the officers of the South Carolina State Dental Association, faculty members and the Chairman of the Board of Trustees, and the President of the South Carolina Medical College, as well as members of the legislature who sponsored the bill. Doctor Clarence E. Saunders, President of the South Carolina Dental Association, stands directly behind Governor Byrnes.

The $10 award for this photograph will be sent to the Relief Fund of the American Dental Association at the suggestion of the South Carolina Dental Association.

Ten dollars will be paid for the picture submitted and used in this department each month. Send glossy prints with return postage to ORAL HYGIENE, 708 *Church Street, Evanston, Illinois.*

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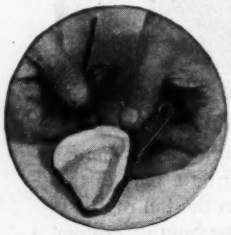

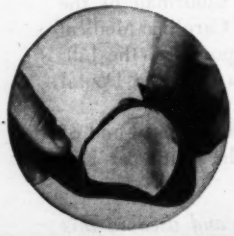

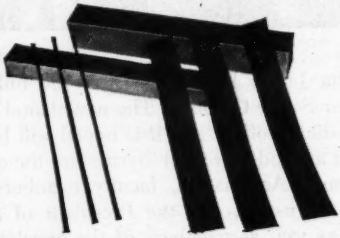

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We Are Tired of Playing Villain

BY DOUGLAS W. STEPHENS, D.D.S.

The wrong type of dental humor on radio and television programs can affect patients adversely.

ON A RECENT television program called SHOW OF SHOWS, an extremely good actor portrayed a dentist with the viewing audience as the patient. The comic, burlesque caricature of dentistry was both humorous and ludicrous. We dentists laughed as loudly as the others when the TV dentist, after peering owl-like into the mouth of his supposed patient, went happily to the telephone and called his wife.

"It is all right to order that new Cadillac," he tells her. Then looking again into his patient's mouth and apparently deciding the dental service to be performed must be quite extensive, he returns to the 'phone, "And honey," he says, "you might as well get that mink coat you have always wanted."

Now we dentists do not mind this type of humor too much. We realize almost everyone forgets to budget for health services, and when dental expenses arise, home economics are thrown out of line. Then everyone thinks the other profession or job is the more lucrative, and it is funny when this is played up, whether it is the butcher, the landlord, or the dentist who takes the brunt of the joke.

However, it was what followed this make-believe scene that raised the short hairs on the necks of the members of the dental profession.

Turning back to the patient, this SHOW OF SHOWS dentist picks up an emery wheel of such great size that any dentist would hesitate to use it in the laboratory, and never within sight or hearing of a patient. Inserting this monstrosity into the dental handpiece, he proceeds to grind on a phantom tooth. As the sparks fly, everyone is supposed to laugh. And I laughed too, at first, until I began to wonder how this type of humor would affect dental patients across the country, next Monday morning.

It was not long before I learned. On the Monday noon following this coast to coast telecast, I met a colleague of mine at a service club luncheon. He was looking rather the worse for wear. One of his patients, he told me, little Mary Jones, age 7, had entered his office that morning and, upon seeing the dental chair and equipment, broke into loud sobs.

"The sparks!" she cried out, hysterically. "I do not like sparks. They hurt!"

Kneeling down beside the child, my friend had gently wiped away the big tears that ran down her freckled cheeks. At first he could not understand why the child was so emotionally disturbed. Mary had always been an exceptionally good patient. In the past he had had no trouble treating the tiny mouth and inserting even the largest type restorations in her teeth. However, this day, no amount of coaxing could induce the child into the dental chair, and only after sympathetic questioning did Mary finally admit that she had watched the "dentist" on the SHOW OF SHOWS program the previous Saturday night.

Although Mary had never been even remotely hurt by this gentle dentist and had no reason to fear dentistry, one short, supposedly humorous, scene in a TV script had torn down the good will and confidence the dentist had taken months to build.

Had it not been for an understanding parent and an extremely patient dentist, the latter spending a great deal of time spread over several nerve-exhausting dental appointments, Mary's confidence might never have been restored to the point where it was before the TV program.

If such understanding and care had not been given, this child might have gone into a period of fear psychosis that would have made it impossible to perform good dentistry in her mouth. It is altogether possible she might have ended up a dental cripple with a mouth years older than the rest of her body, and her general health adversely affected by the poor mouth conditions.

Adults Influenced

Furthermore, it is not always the children that are affected by the scare humor of dentistry that creeps into radio, TV, gag cartoons, comic books, and magazine stories. Many adults subconsciously build up a fear of dentistry that they themselves admit has never been realized in modern dental offices.

Now, we dentists feel we are as good sports as any. We like to laugh as often and as much as everyone else. However, fun is fun, but when it puts fear in the hearts of our children and in many adults; when it tears down the self-confidence the dental profession has taken years to build up, then it ceases to be fun and assumes

the proportions of real tragedy.

Almost everyone today realizes dentistry is not in the Dark Ages of fifty years ago. Today with a long, educational background, almost equal in length to that of medicine; with the modern methods of operative technic and new local and general anesthetics used; no person can truthfully say he fears the dental office.

It may be said that such dental humor as is being featured by some writers today, is pure burlesque. No one will take it seriously. You are right. Most people do let it roll off their minds like the slapstick it represents. However, we of the dental profession know too many people do not take it the way we wish they would.

A Father Protests

Recently an angry father wrote to Red Skelton about a program in which Red made cracks about the horrors of a dental office. Although Red was no doubt referring to the dentistry of the past, this man's small son took it as typical of modern times and could not sleep that night because of fear of a future dental appointment. Someone on Red's staff of writers answered with a curt note stating he was sorry if the program had frightened the child and enclosed an autographed picture of the comedian. This pleased the boy but did nothing to dispel the fear that had been built up in his mind regarding dentistry.

Now, I hear that Red is a great fellow and has children of his own, and more than likely never realized the effects of this script on young minds. He perhaps never saw the letter that was sent by the father. I am sure if he had and if he had realized the harm done, there would have been no more scaring dental scripts on his program.

I am also sure writers, producers, and editors alike, have not been conscious of the harm done to dentistry and, more important, to themselves and their families, by these thoughtless dental jokes. These men have been reaching back into the past and rehashing jokes that were old and trite at the turn of the century.

There is a lot of non-scare humor around the dental office. One morning I met a dental colleague hurrying down the street. His face was red and his usual calm eyes were flashing with anger. When I asked, "Jim, what is the trouble?" he blurted out. "Been out to collect from a patient who owes me for a new plate." "Did you get it?" I asked. "No!" he fumed. "And on top of that, he had the nerve to gnash my own teeth at me!"

You do not have to scare people to be funny. Everybody enjoys good fun, like the gag cartoon I saw in a recent magazine. The scene is a street corner with workmen digging up the street with one

★ ★ ★ ★ ★ ★ ★

ORAL HYGIENE AWARD

THIS ARTICLE by DOUGLAS W. STEPHENS, D.D.S., has won the $100 ORAL HYGIENE award for the best feature published this month.

★ ★ ★ ★ ★ ★ ★

of those big body-shaking, pneumatic drills. From a nearby dental office, a dentist in white coat is beckoning the worker who is operating the drill to come over to his office. The caption under the picture reads, "Boy, Doctor must have found a real cavity this time."

However, in a recent Donald Duck comic strip, one of Donald's nephews bites the dentist's finger. This not only conveys the idea that all dentists are mean and should, like all villains, be punished, but plays havoc with the discipline of our younger patients.

On the other hand, many radio and TV stars have already done a great deal to aid dentistry in building healthy mouths. The other night Sheriff John on our western TV network gave a nice plug for oral hygiene and tooth brushing. Many other writers could do similar good deeds for dental health if only we would show them the way. Many of you dentists know writers and actors. Many of them are your patients. When you have them in your chairs or where you can talk to them, discuss the dangers of poor dental humor and how good teeth can be built on favorable publicity. These men, I am sure, will come to dentistry's aid if we present our story in the right way.

New television stations are coming on the air. Within the next year 1,900 new transmitters of TV will be installed over the country. In the Third District of the Southern California State Dental Society we are working out a program of public dental education to be presented over television in the near future. The chief of staff of our nearby Torrance County Hospital has suggested a dignified program to be worked out similar to the one given recently by the Medical Society on Heart Surgery and Tuberculosis Prevention. Modern methods of transplanting third molars to emphasize the crippling results from premature loss of permanent six-year molars has been suggested as one of the subjects.

The use of our public school puppet show which plays up in storybook style the bad effects of sugar on the teeth and fluoridation education are subjects we are planning to bring on these programs. Films, such as "It's Your Health" and other dental motion picture stories we feel will adapt themselves admirably to the television screen.

Let them laugh at us if they like. Make us economic villains if they please. But do not allow them to put us back in the painful horse and buggy days of dentistry.

823 *Atlantic Avenue*
Long Beach, California

A Look at Anesthetic Risks

Clinical observations show how and when nitrous oxide-oxygen should be administered to avoid unfavorable results.

BY JOSEPH DINTENFASS, D.D.S.

THE CAUSES of the fatalities under nitrous oxide-oxygen anesthesia are: Great emotional excitement or physical exertion by the struggling patient causing a sudden stoppage of a weak heart, particularly when the anesthetic is pushed too far; a cessation of respiration for any length of time that eventually stops the heart, either through blocking of the free airway of the gases into the lungs, or too deep anesthesia with insufficient oxygen. An added danger of the use of a mixture with a low percentage of oxygen is that it may cause cerebral anoxia—damage to the brain because of lack of oxygen in the blood—which may kill, paralyze, or even turn the patient into a mental defective. By proper care, alertness, and eliminating the dangerous cardiac cases, the causes mentioned can be prevented in almost all cases.

However, there is one cause not mentioned in literature that is difficult to recognize and which, in my opinion, is responsible for the great majority of deaths in nitrous oxide-oxygen anesthesia. I call it retarded recovery.

Patients with this peculiarity are typical of a group that outwardly appear perfect risks for nitrous oxide-oxygen and, in many cases, all signs point to a smooth anesthesia, but it is extremely difficult, if not impossible, to bring these patients back to consciousness. Those of us who have administered the anesthetic for any length of time have come across these patients, and perhaps with tragic results.

As a result of my twenty-five years of observation, I believe that it is now possible to eliminate the danger for this group of patients. Who are the patients subject to retarded recovery—those who are so difficult to bring back to consciousness—and how can we make anesthesia safe for them?

First, we must forget some of the things we learned about nitrous oxide-oxygen anesthesia. We were taught that everything was all right so long as the patient continued to breathe, and that when we leveled off the patient at the proper plane of anesthesia, we could keep him anesthetized for any length of time if we maintained that percentage of nitrous oxide and oxygen. That is not true. The patient may be a retarded recovery type and, despite his normal breathing and proper color, may be reaching a depth from which it is impossible to bring him back to consciousness. Then again, even if he is a normal case, deoxygenation may take place. I also believe that nitrous oxide-oxygen should be used only for short operations and never for extended ones.

I have found in my practice that there is a decided difference between the adult males and adult females, and also between them and the younger groups. I have not come across one case of retarded recovery in any patient, either male or female, below the age of 16, where the anesthesia was of short duration. We can therefore assume that the young patient, given the correct percentage of oxygen and properly handled during a short operation, is no less safe than with local anesthesia.

That leaves us with the adult male and the adult female. All the retarded recovery patients have been in those groups, the great majority being female patients. I have found extremely few male retarded recovery patients, but even though rare, such cases may prove serious.

My study has revealed that about three-fourths of the more serious cases are women between the ages of 18 and 35, a small number past that age, and a still smaller number of men between the ages of 20 and 45. Thus, in my practice, I have noted that, with few exceptions, the great majority of these patients were young women, a smaller number of mature women, and a much smaller number men.

Timing of Anesthesia

I have found that the patient who takes a greater amount of nitrous oxide to bring him past the second stage, with a longer interval of time, will, in virtually all cases, come out of the anesthetic quickly. For example, the athletic and alcoholic types come out almost as soon as the nitrous oxide is turned off. Conversely, the serious and dangerous group go into

anesthesia quickly. Of course, there are some patients who take but a small amount of nitrous oxide and come out of the anesthetic without incident, but he or she should be considered potentially dangerous and handled with great caution. *The smaller the interval of time for induction, the more dangerous the case is likely to be. Sometimes as little as four or five inhalations of the mixture will result in a complete loss of the eye reflex with the pulse, respiration and color normal. The thing to do then is to turn off the nitrous oxide immediately and try to bring the patient back to consciousness even without the completion of the operative procedure; for when the patient goes into anesthesia that quickly there is good probability that the patient can be brought back to consciousness only with great difficulty. Hence the eye reflex is the most important guide.*

For example, a young woman between 18 and 35 presents herself for nitrous oxide oxygen anesthesia, I study her face, color of the skin, shortness of breath while talking with her; notice whether there is any swelling of the ankles and ask general questions about her health, without exciting any suspicion or concern on her part. I note that she is apparently in good health, has good color, with no negative conditions present. However, to me she is a potentially dangerous patient, since the great majority of the retarded recovery patients in my office have been young women in that age group. Therefore, at the first appointment, I plan to extract one or two teeth, making the anesthesia of a short duration and checking on her reaction and her recovery time.

I start with 10 per cent oxygen —I may start with 20 per cent oxygen in some cases and reduce it gradually if anesthesia does not take place—and 90 per cent nitrous oxide to a point where I level off the patient to the proper plane of anesthesia. At the end of about twenty seconds, if the patient's breathing, color and pulse are normal with the eye reflex gone, I immediately turn off the nitrous oxide and, with 100 per cent oxygen, I proceed to extract one tooth and bring the patient back to consciousness.

If the length of time were ten seconds, or less, I would not extract the one tooth unless it were extremely easy and could be removed quickly. After the patient has regained consciousness and the recovery time and other reactions are noted, I then decide how many teeth may be extracted at one sitting.

If her recovery time is within safe limits, I will proceed with the other extractions at a subsequent sitting with absolute confidence. Incidentally, the recovery time from the same plane of anesthesia is always constant for some years at least, unless the patient has un-

dergone a great physical or mental strain previously.

Thus, we see that we have two groups of patients. On the one hand, we have the alcoholic and athletic type who take a great deal of nitrous oxide and come out of the anesthetic almost immediately —if we are able to anesthetize them—and the retarded recovery cases which take little nitrous oxide and may be of great concern to us. All the others fall within these two groups. Of course there are other factors besides recovery time that make the patient a safe anesthetic risk. Within the limitations of this article, I cannot go into these.

Dangerous Types

There are different degrees of retarded recovery. The more serious and dangerous type follows a certain pattern. The patient goes into deep anesthesia after but a few inhalations, with the eye reflex completely gone; and the respiration, color, and pulse may be normal. The nitrous oxide is turned off and, with straight oxygen, it is difficult and sometimes impossible, unless immediate action is taken, to bring the patient back to consciousness. Success will depend in these cases on the amount of nitrous oxide that was inhaled and the duration of the anesthesia. Therefore, in these extreme cases, nitrous oxide should be turned off immediately and every effort should be made to bring the patient back to consciousness as quickly as possible.

We do not know when this dangerous type will come to the office. He or she may come today, tomorrow, next year, or in five years. Alertness and knowing how to handle the patient, will save a life and avert a tragedy. Outwardly these patients may appear to be ideal cases for nitrous oxide-oxygen—young, healthy, and full of life.

We cannot shrug off retarded recovery fatalities as one of the risks to be expected from general anesthesia. It is true that, during general anesthesia, life's processes are suspended with the exception of respiration and the action of the cardiovascular system, but the procedure can be made much less risky than is generally believed.

When retarded recovery cases are handled routinely, according to the foregoing procedure, they cause little or no concern, except the serious and dangerous cases. Even in those cases, by promptly turning off the nitrous oxide as soon as the eye reflex is lost and giving the patient straight oxygen, it is possible in virtually all cases to bring the patient back to consciousness and save a life.

Not only can lives be saved, but the operator can work with a greater degree of confidence and less nervous tension on his part.

472 *Broadway*
Bayonne, New Jersey

How Old Are Your Patients?

Children will visit the dentist's office more consistently if their mothers have received correct prenatal instructions.

BY CHARLES P. FITZ-PATRICK

YOUR APPOINTMENT book is probably dotted with names of some of the children who have grown out of the record-breaking 2,300,000 marriages of 1946. At least it should be, and for a practical reason, too.

This movement of the postwar infants toward dental chairs logically brings up the question of your own age, and the dollar profits you may expect from your practice in the years to come.

You probably find it comforting on your birthday to know that your friends and the fellows, with whom you graduated from dental school, are keeping right in step with you. However, the subject of multiplying years turns serious when patients are brought into the discussion. In a healthy practice, those who call for appointments must enjoy lingering youthfulness.

According to one practitioner who has given the matter considerable study, at least 50 per cent of a dentist's patients should be less than one-half the age of the practitioner. The closer the average age of patients approaches that of the dentist, the sooner his practice is due to suffer a serious decline in productive chair time.

Of course, the reason for this is simple. A patient, advancing from childhood to maturity to middle

age, is likely to require increasing hours of dental attention. But then, the complete denture stage is reached and the man or woman is lost as a source of regular income. Equally important, this class of former dental patients is not likely to have children young enough to originate the child-adult-middle-age cycle at its starting point. A mathematician might formulize this lost patient situation as one minus one equals zero. A continuing, robust practice, on the other hand, might be represented as one plus one equals three.

Indoctrinate Mothers

This probably was in the mind of a dentist who recently explained to the girl in his chair, how today's youngsters are benefiting from advancements made in prenatal care. The patient, a girl of about twenty-four, listened attentively as the dentist pointed out that, on the advice of pediatricians, parents no longer consider "baby teeth" expendable, and thus not deserving professional attention. The subject of the conversation was prompted by the obvious pregnancy of the patient. Even though the anticipated newcomer could not be expected in a dental office for some time, its mother's awareness of the part modern dentistry plays in child-health and appearance was broadened by the practitioner's informative comments.

The conditioning of parents' thinking in 1953 is more vital than ever before. As mentioned previously, dental patients in the five, six, and seven-year-old groups, are at an all-time high and the total is not likely to be equaled in the near future. Although marriages in the United States are continuing to run above average, the year 1952 showed a drop of nearly 800,000 below the 1946 figure. This means hundreds of thousands fewer school-age patients around 1960.

Under our economic system, the opportunities for advancement in virtually every field—and this includes dentistry—are said to increase with the growth of the population. Larger numbers sumed to require more services and materials which, up to a certain point, is a logical theory. However, before a demand becomes evident, there must be created a desire to exchange dental disease for the promised benefits. The absence of such a demand was clearly indicated at a meeting of an eastern dental group, when a speaker pointed out that approximately 84,000 dentists in this country show an average of 600 patients each. A little multiplication exposes the startling fact that nearly two-thirds of civilized and prosperous Americans appear unwilling to trade dollars for the health and appearance advantages of dentistry. For them, there is no desire and thus no demand.

Not long ago, a half-dozen dentists were asked if they could

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Memberships in local groups and standing in the community, offer you an excellent opportunity to give interesting and factual talks on the subject of dental health.

When addressing Parent-Teacher gatherings, Rotary or Kiwanis meetings, or other groups, dentistry can be made an absorbing subject without any "see your dentist" references.

One dentist has developed a ten-minute address dealing exclusively with the part teeth play in preparing food for correct and easy digestion. To give his listeners a "catch line" they are likely to remember, he repeats several times during his talk the words, "Remember, there are no teeth in your stomach." He developed this subject to its present length when he learned how little most laymen know about why the individual teeth are shaped and positioned to perform certain tasks.

This, or an equally informative subject, will be welcomed by the groups to which you belong.

pin-point a single factor that prompted the making of appointments for youngsters. Although the responses varied, it was indicated that almost all of the calls came from parents who also avail themselves of regular dental care. This evidence, that the practice of intelligent dental habits are passed along within the family circle, clearly indicates the wisdom of the practitioner's talk with the mother-to-be.

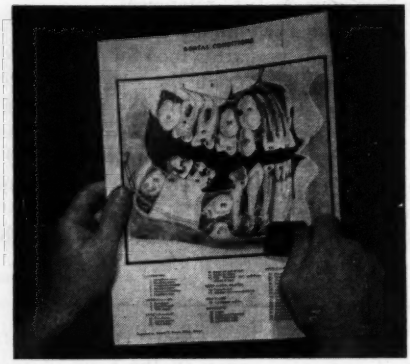
Offers Report Cards

In an attempt to broaden the benefits of this parent-to-child influence, one worker, employed immediately outside the professional phases of dentistry, has offered his local school board a budget-saving suggestion. His plan is to furnish free report cards in return for space on the back of each for a dental lecture. The illustrated "talks" would be designed to apply to the age groups of the students for whom the report cards would be prepared. Back of the idea is the sound belief that, while classroom discussions on the proper care of the teeth are desirable, the action necessary to bring dentist and child together is put into motion by the parent. The report cards with the lectures would be carried to parents each month or each quarter. Naturally, no authorship or credit lines would accompany the illustrated lectures.

Regardless of the methods, plans, or ideas applied to the task, the need for dental knowledge is

(*Continued on page* 1094)

"Mrs. Patient, We Must Remove Your Teeth"



Make a careful study of your patient's oral condition first, then tell him frankly but tactfully what must be done.

BY LEO B. DILLON, D.D.S.

MY ASSISTANT called me to the telephone. Over the wire I heard: "This is Mr. Blank. My wife was in your office this morning, and you suggested pulling all her teeth. Cancel her future appointments! I am taking Mrs. Blank to Doctor I. M. Big, a specialist." His tone convinced me that his decision was final.

Mrs. Blank was middle aged, socially prominent, active in church and clubs—a problem case so typical of the middle aged woman in the menopause. She sat in my chair for the first time. My examination of her mouth showed four posterior, unsanitary, septic bridges, anterior teeth with receding gingivae, serumal calculus, and deep pus pockets. Her teeth were mobile from advanced pyorrhea. She queried: "Well, Doctor, what can you do for my teeth?" I said bluntly: "Extract every one of them!" Her facial expression told me I had spoken with cruel frankness. Halfheartedly, I pointed out the looseness of her teeth, the pus around them, and told her

how hopeless they were. Thus terminated her first appointment.

This Doctor Big was a specialist in periodontal diseases and depended upon scaling and drugs for his treatments. My bungling of Mrs. Blank's case cost her one year of physical harm from pus and toxin absorption, needless suffering from Doctor Big's treatments, not to mention her financial loss. I lost the good will of the Blanks, lost reference of new patients by them, and lost the fee they would have paid me for services rendered.

Then Mrs. Blank returned to my office. From my dental chair, she said: "Doctor, I am ready to have you pull my teeth." Regardless of evident symptoms, I had learned that a snap diagnosis is never wise. The patient must feel that sufficient time and study has been made of his case before a diagnosis is given.

When Mrs. Blank queried during her first visit to my office: "Well, Doctor, what can you do for my teeth?" I should have answered: "My very best, but first I must make a thorough examination and study. We will begin our examination with full mouth x-rays, which will disclose the diseased lesions surrounding the teeth and extending beyond the root ends. The extent of these diseased lesions will decide the fate of your teeth." I should have called Mrs. Blank's attention to the inflamed gingivae, the deposit of salivary and serumal calculus, the receding gingivae, the mobility of the teeth. Next, the clinical examination, when I would bring to Mrs. Blank's attention every defect such as caries, overhanging margins of crown and restorations, and pyorrhea pockets. The study casts of teeth and jaws would follow.

Report Findings

At this stage of oral diagnosis, Mrs. Blank should be almost convinced of the utter hopelessness of retaining her teeth. Between this and her next appointment, study would be made of her roentgenograms, the clinical examination, history, study cast, and her personality. I would request Mr. Blank's presence at the presentation of her case. With Mrs. Blank and her husband seated at my desk, with her case data before us, I would point out the pathology of her case, confirming many facts evident both from the roentgenograms and the study cast, such as lack of bony support, elongated teeth or marked receding gingivae. I would show some contrast such as marked bone absorption and no receding gingivae or elongation. This would lead up to my question, "Mrs. Blank, shall I be absolutely frank, even if I must tell you something displeasing?"

"The roentgenograms and the study model of your natural teeth show clearly the progress of dental disease in your mouth. Disease has reached the stage where it is im-

possible to save your teeth. The teeth are so small, with such weak root strength, that I cannot recommend that you spend money needlessly for partial dentures. The positions of these teeth are such that they would break the valve seal so necessary for you to be comfortable and happy with any partial replacement. The additional load that clasps or stabilizers would place on them would cause them to become sore and uncomfortable. They would soon loosen, necessitating removal, with resultant bother and expense to you. I recommend partial dentures when they will be more comfortable, more efficient, and enhance your appearance over full dentures. However, when it means a large investment of both time and money, it seems advisable to decide on the course that will serve your best interests all around. In your case, you will be better served with full dentures. I know how you must feel about losing your natural teeth—my reaction would probably be the same as yours if my own teeth were involved. From a careful study, I am convinced we should remove your teeth now and replace them with full dentures.

"In construction, modern dentures are scientifically individualized. They hold the facial muscles at full length and prevent them from sagging. This restores the natural form of the face and maintains youthful appearance, in accordance with your personal characteristics. Research laboratories have produced teeth that defy the most critical eye in their likeness to natural teeth. You are unaware that many of my patients, with whom you are acquainted, wear dentures. You can have individualized dentures that will restore that supreme joy that goes along with the satisfaction that you can give full, free expression to your personality. This you can do when you know that your facial appearance is the best, and that you can smile and laugh without restraint. You will have that superb poise, which comes with complete forgetfulness of self. The eyes of your friends and associates will give you no feeling of inferiority. Your voice will take on a richer, more resonant tone, because you will be relaxed, natural, and more convincing in your contacts. You will be your "old self" again. This superior dental service can be rendered for the modest fee of $_____."

No Deception

From this presentation, you can see I have stressed appearance, mental, and psychologic satisfactions. I have not promised freedom from discomfort, neither have I made any promises as to ability to masticate food. Since full denture cases represent individualized service in the profession, it follows that case presentation must be as individualized as the service. To a patient who has come to you for the first time, with no idea of

the seriousness of his mouth condition, the disclosure that all his teeth are lost is a terrific shock.

Now for us, all is not lost. With such a positive let-down we must have a constructive build-up. We must make the patient realize the futility of attempting to retain any of his teeth, his responsibility in acquiescing to your suggestion of removal and replacement with full dentures, and the necessity of *conquering* them. Our problem is to have our patient accept cheerfully and willingly a service he did not come into our office to receive and did not want!

Problem Cases

There are many types of patients —only the most frequently encountered problem cases will be mentioned here. There is the patient who is timid, slow, indecisive, and suspicious. This patient shows little interest in your case presentation, makes no comment, just sits and stares at you. Look him in the face and in a kindly manner state: "Well, that's your dental problem and my solution for it. What do you think of it?" Be silent awaiting his answer. He will usually ask some question having little bearing on his case. Nevertheless, answer him fully and then come back to his case. Repeat the last statements made in his case presentation and again ask: "This is your dental problem and my solution of it. What do you think of it?" Usually he either accepts your proposition or says, "I will have to think it over," or "I will have to talk it over with my wife." Now it is time for you to guess—does he sincerely want to think it over or talk it over with his wife, or is he stalling? If his wife is present, turn to her and say: "Is everything perfectly clear?" Then restate pertinent facts of his case. If his indecision causes him to hesitate, be kind and try to help him reach a decision. Explain the cost of his delay, then tell him that you cannot guarantee that the cost will be the same if he delays taking action.

The shopper is a problem. He considers his dentist's fees too high or lacks confidence in him and wants the opinion and price of another dentist. Frequently, he brings a set of roentgenograms with him, and says: "Doctor, what do you think ought to be done to my teeth?" My reply might be, "Mr. Prospect, sit down and let me examine your mouth clinically." If price is his motive, he may say: "Doctor, are you going to charge me for this?" I reply, "Yes, Mr. Prospect, if my opinion is worthless, then there is no point in my giving it." Make a thorough clinical examination, including history, and a study model. Use every means possible to obtain detailed information about this patient. Then you will be able to present his case effectively, thereby discouraging him from seeking professional aid elsewhere.

Dentists often are confronted with the problem patient who wants full dentures and does not need them. He believes he can have his teeth removed, get full dentures, and end his dental problems. He has spent a few hundred dollars on his teeth; neglected them; the restorations are not "permanent," and, he rationalizes, "Why spend more on them?" Disclose to him the limitations and lack of "permanence" of artificial dentures. Explain the function of natural and artificial dentition. Tell him that only in the mouth do hard tissues come in contact in a mechanical action, which is subject to the same hazards as mechanical action anywhere, with wear, breakdown, and age—the care of his teeth can be compared with that given his automobile. Inform him of the hazard of caries and gingivitis.

Loss of the teeth as a result of our diagnosis is a serious responsibility for both the dentist and the patient. Our responsibility goes further than just a final, correct decision. We must prepare the patient to resign himself to the edentulous condition with the conviction that many years of health and satisfaction will result. We ought to set a value on our opinion, particularly when it involes the serious responsibility of diagnosis. Accurate diagnosis can only be attained through weighing all factors with meditation and deduction. Truth, tempered with tact, as to the limitations of his dentures, should be disclosed to him. The ultimate result will be confidence that he has the desire and determination to learn to use them successfully.

916 *Woodward Building*
Birmingham, Alabama

THE COVER

THE BEAUTIFUL picture of Wade Park and the Cleveland Museum was taken for this month's cover by our photographer, Howard A. Hartman, D.D.S. This will be one of the centers of interest for delegates to the Ninety-Fourth Annual Meeting of the American Dental Association, which will be held in the Cleveland, Ohio, Auditorium, from September 28 to October 1, 1953. To be assured of suitable hotel accommodations, delegates are urged to make reservations as soon as possible through the American Dental Association Housing Bureau, 511 Terminal Tower, Cleveland 13, Ohio.

I Am Happy Away from Dentistry

BY FRED T. JOY, D.M.D.

This dentist finds new and absorbing interests outside of his profession.

AN AUTHOR phrases the question in the form of a title: WOULD YOU BE HAPPY AWAY FROM DENTISTRY? for an article published recently in ORAL HYGIENE.[1] From my happy experience during the past year and one-half, since I have left my profession in favor of business interests here in Florida, I would use virtually his same words with a slight twist and addition: YOU WOULD BE HAPPY (AND HEALTHY) AWAY FROM DENTISTRY!

Without adopting the many pet phrases such as: chained to a chair, crowded appointment schedules, office-worker pallor, richest dentist in the local cemetery, and rushing around on roller skates, let me state my case with the fewest possible words. While I enjoyed a lucrative northern practice, I was not getting the most out of life. I felt that there was not enough time to spend with my family. Three times my appointment schedule was cut down—no Saturday afternoons, no evening appointments—yet I was overworked and tired, and not too agreeable to get along with either.

One day I sat down in my business office and asked myself the following questions: (1) Am I happy and contented? (2) Do I

[1]Travascio, M.: Would You Be Happy Away From Dentistry? Oral Hygiene **43**:637 (May) 1953.

enjoy enough leisure time? (3) While I am in excellent health now, will I continue to enjoy good health after fifteen or more years of back-breaking, confining dental labor? I marked up three big "Noes."

Yes, I also reviewed my life insurance policies and other assets, and came to the conclusion that my loved ones would be provided for adequately in case "something happened to me." But other than an accident, just what would that "something" be? It could be but one conclusion. I thought it over, and even went so far as to consult my insurance agent, a nearby friend. He showed me the statistics which prove that dentists have a high mortality rate. I did not need his figures as I recalled that many of my fellow dentists had died before reaching the age of 50. Others had been warned to "take it easy," and take a long rest cure. Some did, many did not.

What is it that kills a dentist? We are aware that he must have a high degree of physical stamina and be possessed of "a sensitive, understanding temperament." No, he will not "rust out" but he will "wear out" and unless his machine is well lubricated with rest, fresh air, sunlight, and freedom from worry, it will run down and *out*.

Since coming down here to semi-retirement, I feel as if I have a new lease on life. I have plenty of leisure time for the beach, and I also carry on a business that is remote from dentistry. It is a relaxing occupation with a desk job and title of Office Manager. The salary, though less than I made in dentistry, is adequate for our total monthly overhead, plus a tidy sum for the savings account. I also am Executive Vice-President of the Tropic Art Company; my wife is the President. We manufacture an art product that is made from materials found in the Everglades. It is an interesting and profitable occupation. Mrs. Joy does most of the assembly work, while I manage our small, but growing, business venture.

I feel that I am 100 per cent better off down here in this tropical wonderland, and would not trade places with any of you boys from Park Avenue to the Golden Gate. Here, I have found peace of mind, contentment, with all the necessities of life, and a number of luxuries thrown in on a modest scale.

So, if you are tired of dental routine and feel that you can adapt yourself to a new occupation where you can enjoy a better climate, then I advise you to look to south Florida. You do not need $50,000 to make the break, but should have enough to tide you over until you become adjusted. Our wonderful sunshine, fresh air and the beach are free to everyone, whether he is rich or poor.

1110 *North East Fourth Avenue*
Fort Lauderdale, Florida

DEAR ORAL HYGIENE

The Dental-Medical Draft

The dental and medical draft, organized by the government forces in 1950, resembles a reprisal for the antisocialized medicine stand taken by these two professional groups.

The dentist and physician study from six to ten years in school, during which time they spend from ten to fifteen thousand dollars toward the completion of their respective courses; not to mention the loss of earning power that is estimated at fifteen to twenty-five thousand dollars during these years. Then the dentist or physician spends four to ten thousand dollars in opening an office, plus two to three years of bare existence to meet overhead! At this point, he is potentially twenty-five to forty-five thousand dollars behind the person who did not attend the professional schools.

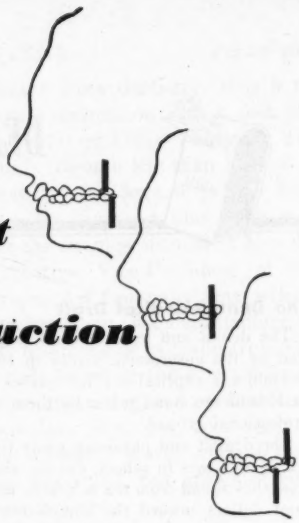
Then, what happens? The Army steps in! They disregard age (up to 51); they overlook the number of dependents (up to five); then ignore physical condition, and just say, "Come!" They disregard years of study, the loss of money, the hard work to build up a practice—and compensate you with three to six hundred dollars a month! What becomes of your clientele and office? After two years you come back—to two more years of rebuilding and self-denial in the interim? Does the Armed Forces pay rent on office or storage? No! Do they pay for loss of time? No! Do they pay you a reasonable amount for the services you render? No! You are in and that is all there is to it.

What of the other professional men—the osteopath, the chiropodist, the optometrist, the chiropractor, the naturopath, the psychiatrist, the illegitimate dental technician, and the neurologist? Why are they not called? Why are they left behind? They are left behind to milk the professions of dentistry and medicine of the cream that is due drafted dentists and physicians, through years of work and hardship. They take over where the dentist and physician left off. The gravy train!

It is time that some realistic legislation is brought about. Place the dentist and physician in the Army on a piecework basis—pay them per restoration or per treatment—let them earn what they did in civilian life! They worked for it! If this were the case, only one-third of the medical and dental forces would be necessary today, and mature men, with children and physical disability, would cease to make a laughing stock of the Army. Is the United States really so destitute? A country spending billions abroad cannot spend money to build dental and medical schools? Wake up Americans and learn what is happening to your country! — JOHN P. KALIN, D.D.S., 3123 *North Clark Street, Chicago* 14, *Illinois.*

FELLOWSHIP

IN A family, fellowship ought to be at its maximum, sovereignty at its lowest possible minimum.—*Mental Health, Abraham A. Low,* M.D.



Dentistry's Part in Speech Production

Cleveland dentist urges his colleagues to use their knowledge of anatomy to aid children with speech defects.

BY HOWARD E. KESSLER, D.D.S.*

THE FACT that speech is one of man's greatest faculties is known by virtually everyone. The fact that dentists play a leading role in speech correction is known by relatively few.

Often, some dentists themselves do not fully realize that their specialized knowledge of the human body can be used to correct defective speech, and to maintain normal speaking ability. However, in this respect, the dentist is no different from any other professional man.

Although speech has always been the most important medium for the communication of ideas, it has been, until recent years, one of our most neglected and misunderstood faculties. When one realizes that down through the centuries the spoken word has been one of the chief forces behind all human progress, it is difficult to understand why so little has been known about normal speech production. One reason suggested is that we have nothing in our bodies which can be classified specifically as speech organs. The articulatory muscles are primarily muscles of mastication; the muscles which form the power or "bellows" of the voice are muscles which we use to sustain life in breathing; even the vocal cords themselves are primarily for the protection of the trachea.

As to the role of dentistry and all of its specialties, we know that speech defects can be caused by malocclusion, loss of teeth, tongue tie, incorrect dentures and bridges,

*Doctor Kessler is Dentofacial Speech Consultant for the Cleveland, Ohio, School System of the Cleveland Board of Education.

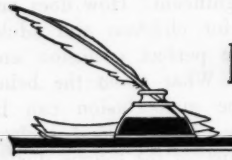
cleft palate, shortness of soft palate, and fear of showing unsightly dentition. In this particular article, we are concerned only with the articulatory problems of speech as caused or influenced by malocclusion, loss of upper anterior teeth, and wide spacing of upper anterior teeth. The exact relationship of speech defects to malocclusion is still open to question. In trying to arrive at a more definite understanding of the problem, I began a study more than three years ago in collaboration with Mrs. Amy Bishop Chapin, assistant chief of Hearing and Speech therapy at the Cleveland Hearing and Speech Center of Western Reserve University. This long range study, which is to cover the examination of several thousand children, is not yet completed.

Here are some of the questions to be answered by such a study: Why do some children with severe malocclusion have perfect speech? Do these children compensate for their malocclusion by compensatory lip and tongue placements because of a high I.Q.? Do these children compensate because they are surrounded by parents and friends who have good speech and whom they imitate? Does the exact amount of overjet of the arches decide whether or not this child will have difficulty with his sibilant sounds? Has the width of the upper arch anything to do with it? Has the height of the palatal vault any influence? Is the width of the palate significant? How does one account for children and adults who have perfect occlusion and yet lisp? What about the belief that some malocclusion can be caused by a speech defect, such as the pressure of the tongue during faulty speech tending to push the upper anterior teeth into protrusion?

In an effort to answer some of these pertinent questions, exact, significant mouth measurements have been and are being made of the following three groups: (1) All known articulatory speech problem children in the Cleveland School System; (2) Children with malocclusion who have no speech defects; and, (3) Children who have both normal occlusion and normal speech.

As I have said, the final results of this study are not yet available. However, the following information would seem to substantiate dentistry's important place in the field of speech. While sampling at random in the Cleveland School System, 100 articulatory problem children were examined and only seven were found to have normal occlusion. This experience can be repeated again and again in pursuing a study of this type. I would be interested to hear from dentists who have conducted similar studies on speech defects in school children.

The Park Building
Cleveland, Ohio



EDITORIAL COMMENT

"Give me the liberty to know, to utter, and to argue freely according to my conscience above all liberties." *John Milton*

HOW MUCH IS A LITTLE BUSINESS RECESSION?

THE WORD is going around Washington that an effort will be made to produce "economic adjustments." This is a delicate and euphemistic way of saying that a deliberate attempt will be made to create a business slowdown. Economists who think this way believe that a little price-cutting, a touch of unemployment, are wholesome for our lives.

In the past we saw economists at work who had a diametrically different point of view. Cheap money, high taxes, lavish government spending, created full employment, higher prices, and inflation. Under this system many people handled more money than they had previously, and people in the lower income groups were better off. They bought cars and homes and dental care.

Dentists under the inflationary spiral were working to near capacity and handling considerable money. They were also paying higher prices for everything and putting out substantial sums in taxes. In general, they did very well in their net profits.

Large business and the giant corporations, under the stimulus of inflation, had higher production costs and higher profits. They chafed under the domination of the labor unions who kept demanding higher pay and more fringe benefits. But, even so, the earnings and the dividends of corporations reached all-time highs.

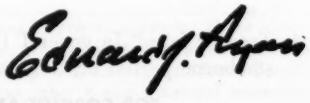
A runaway inflation certainly must be controlled or the economy will get completely out of hand. People living on fixed incomes are faced with destitution under uncontrolled inflation, but unfortunately governments are not concerned with people on fixed incomes. They have no lobby to protect them. The labor unions vociferously represent the workers. The National Association of Manufacturers and the United States Chamber of Commerce are well able to present the point of view of management. Although most dentists are disposed to be more sym-

pathetic to the philosophy of NAM and C of C than to that of CIO and AFL, the fact is that dentists prosper most when more people are in the position to buy professional service. Unemployment, tight money policies, and a deflationary trend, will force millions of people out of the dental market.

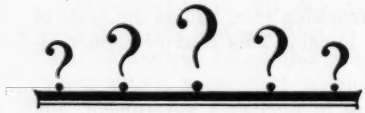
It would be difficult to write a brief in favor of inflation. It would be even harder to write one in support of a program of economic adjustment that deliberately created unemployment and made money tight. Inflation, although unwholesome, creates a buoyant feeling of optimism in the public mind. People earn well; they spend freely; they save a little; and they pay out excessively in taxes. It is an unnatural condition, but stimulating, like a drunken spree. Deflation, however, is a demoralizing force. The word depression describes the depths of the emotional experience. Fear, abject terrorizing fear, haunts the souls of the unemployed, the debt-ridden, the hungry. This country cannot afford another depression.

A doubt is in the minds of many as to whether a government, any government in the world, can control a business recession. Some of us suspect that a "little recession" is as hard to control as a "little cancer." Either one, when it starts, quickly develops into a malignant form. The business executive who believes that union leaders have got out of hand and that their power must be broken by a "little unemployment," may find that their markets have collapsed under this scheme and that corporate bankruptcy is the deadly aftermath of unemployment.

Our enemies, the Communists, are not unmindful of the class struggle, the tension between management and labor in this country. They will do everything possible to stimulate the growth of ill will among groups of our people. The Communists know that one way to destroy our military potential is to create disharmony within our Nation. At no other time in the history of the country has it been so necessary to control our passions and economy. We cannot afford an exclusively labeled "business administration" or a "labor administration" in Washington. We need a *united-people* government.



So You Know Something About DENTISTRY!



QUIZ CVII

1. Mesio-occlusion of the mandible usually exhibits (a) an increased length of the face, (b) overeruption of the bicuspids and molars. _____

2. Why should oxidized gauze or cotton never be used as a surface dressing except for the immediate control of hemorrhage? _____

3. A decreased vertical dimension means (a) loss, (b) no change, (c) increase, in muscular power. _____

4. True or false? In general, tissue-borne partial dentures are those which involve the retention of not more than three of the patient's own teeth. _____

5. To obtain absorption in appreciable quantities, the oral dose of penicillin must be (a) 2, (b) 4 or 5, (c) 10 times the parenteral dose. _____

6. Why should tungsten carbide burs be applied to the cavity while in motion? _____

7. Is it possible for the pulp to retain its vitality in the presence of a lateral or pericemental abscess? _____

8. True or false? The thickness and structure of the periodontal membrane are influenced by the demands made on it. _____

9. Xerostomia results in (a) loss of the detergent action of the fluid saliva, (b) accumulation of debris in the mouth, (c) halitosis, (d) a characteristic coated tongue. _____

10. Are posterior bitewing films considered more accurate for the interpretation of coronal conditions than other films? _____

FOR CORRECT ANSWERS SEE PAGE 1096

Dentists in the NEWS

San Diego (California) Tribune: In "recognition of outstanding service to dentistry," Captain J. A. Tartre, USN, 11th Naval District dental officer was presented with a plaque by the San Diego County Dental Society at their monthly dinner meeting in the San Diego Club. Captain Tartre, who retired in June after 34 years' service, was also made an honorary life member of the Society in appreciation of his efforts to promote good relations between Navy and civilian dentists.

Philadelphia (Pennsylvania) Inquirer: Doctor LeRoy M. Ennis, professor of oral roentgenology in the School of Dentistry and the Graduate School of Medicine of the University of Pennsylvania, has received a Fulbright Professorship to Fuad I University of Cairo, Egypt, from the United States government. He will be granted a leave of absence and will leave September 1 to take up his duties as visiting professor. While in Cairo, he will aid in rehabilitating the dental education program and assist in modernizing teaching methods and dental techniques to raise public health standards. Doctor Ennis is a Past-President of the American Dental Association.

Raleigh (North Carolina) News and Observer: Doctor Ernest A. Branch of this city, who has headed the Division of Oral Hygiene of the State Board of Health since 1929, was honored by the North Carolina Dental Society at their annual meeting. He was especially commended for the plan of dental health education he developed, which is recognized in dental education and public health circles as the most effective of its kind in the United States. He also founded the Institute of Public Health Dentistry at the University of North Carolina and directed it from 1936 to 1942. He is a Past-President of the American Association of Public Health Dentists.

Los Angeles (California) Daily News: Whittier's pioneer dentist, Doctor Milus M. House, was honored on his fiftieth anniversary in the dental profession at a Miramar Hotel dinner, given by the Pacific Coast Society of Prosthodontists, of which Doctor House was a co-founder in 1930. Doctor House also aided in founding the American Academy of Denture Prosthetics in 1918 and the American College of Dentists in 1920.

New York (New York) Times: Two New York dentists, Doctors Irwin Eisenfeld and Edward U. Friedman, have prepared themselves to give specialized dental care to victims of cerebral palsy. They have just completed a pioneer two-year course offered by Columbia University, part of a postgraduate program established by the School of Dental and Oral Surgery and the United Cerebral Palsy Association of New York. The dentists have not only taken courses relating to dental subjects but have also studied neurology and child psychology. During the academic year, they have treated cerebral palsy patients in a clinic twice a week.

Long Beach (California) Press Telegram: Over an eight-month period, Doctor Richard L. Cassel, a Redondo Beach dentist, who is also a natural scientist,

has made a special study of pallid bats. He and Mrs. Cassel have kept these bats in their home for several months and taken many photographs of them while flying, eating from their hands, hanging upside-down from picture frames. Pallid bats, which are native to California, are insect eaters and helpful in controlling harmful insects, according to Doctor Cassel.

New York (New York) Jewish Veteran: The "Make a Toy" contest conducted among disabled veterans for underprivileged children is one of the many projects which take up the free time of Doctor N. Howard Hyman, New York Hospitalization Chairman for Disabled Veterans. A practicing dentist, the 57-year-old Doctor Hyman, has spent most of his evenings in the last fourteen years working for the Jewish Welfare Board, as well as other agencies.

Fairmount (Minnesota) Daily Sentinel: One of the oldest practicing dentists in Minnesota, Doctor W. A. Demo of Blue Earth, celebrated his 84th birthday on May 15. After practicing dentistry in this state for fifty-seven years, he estimates he has served more than 15,000 patients. Some of them have been coming to him regularly for fifty years. His office hours, he explains, are not as long now as they used to be. He works only from 9 to 5 and takes an hour and one-half for lunch.

Los Angeles (California) Times: The American Board of Orthodontics has given Doctor Spencer A. Atkinson, head of the Department of Graduate Orthodontics in the University of Southern California School of Dentistry, the Albert H. Ketcham Memorial Award. This highest honor in the field of orthodontics was presented to Doctor Atkinson because of his pioneering in this branch of dentistry. Next to his home in Pasadena, he has built an eight-room fireproof, air-conditioned building, which is the world's only privately owned, supported and conducted laboratory for anthropology research as related to orthodontics. Doctor Atkinson serves on the faculty of five universities. He has been a visiting professor at the College of Physicians and Surgeons in San Francisco since 1938. He also lectures at the National University of Mexico, University of Guadalajara, and at the University of Yucatan.

Buffalo (New York) Courier-Express: A 46-year-old Williamsville dentist and former national all-bore title holder, Doctor R. F. Westermeier, shot a perfect 100x100 to capture the 20-gauge crown in the fifteenth annual New York State skeet championships at the Buffalo Trap and Field club.

Des Moines (Iowa) Tribune: For nearly fifty years Doctor Helen Towle Dearborn, 74, has been practicing dentistry in her home town Red Oak. She was one of six girls in a class of 155 dental students graduated from the Northwestern University School of Dentistry in 1904. Besides carrying on her dental practice, Doctor Dearborn has found time to develop hobbies. She builds birdhouses for martins or wrens, which have been distributed from Iowa to Washington, D. C. She also likes to construct radio sets and work in ceramics.

Long Island (New York) Daily Press: In his spare time Doctor William Eccleston of Colesville, Maryland, is a chinchilla rancher. For three years he and Neal Sparks, Seat Pleasant, Maryland, another chinchilla rancher, have worked jointly on the problem of malocclusion in these small animals. Chinchilla teeth —sixteen molars and four incisors— grow constantly and are kept trimmed to proper length by normal chewing and grinding. With malocclusion, the entire jaw can be thrown out of line, causing faulty nutrition and eventual

loss of the animal. Although malocclusion strikes only about 2 per cent of the chinchilla industry, the loss is considerable, as a pair of chinchillas brings about $1500. For treating the chinchillas, Doctor Eccleston has had to order special equipment small enough to use in the mouth of an animal that weighs less than a pound.

Philadelphia (Pennsylvania) Daily News: Doctor Louis Menaker, a dentist who also writes songs, has been elected president of Music Scholarships for Youth in Philadelphia.

New York (New York) Times: Just as Doctor Solomon J. Satine, 64, was about to extract two upper incisors for a patient, an automobile mounted a sidewalk and crashed into the two windows of his ground-floor office at 563 St. Paul's Place in the Bronx. Neither the dentist nor his patient was injured. The driver of the automobile, Santiago Gonzales Toro, suffered a sprained ankle. After the debris was cleared away, the dentist moved his patient to another chair and extracted the teeth.

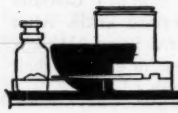
Buffalo (New York) Evening News: The Jarvie Fellowship Award for "distinguished service in the field of dentistry" was presented to Doctor Jay G. Roberts, 72, of 471 Linwood Avenue, Buffalo during the 85th annual meeting of the New York State Dental Society. Doctor Roberts was president of the Society in 1933, and Editor of its *Journal* from 1933 to 1942. He served for thirty-three years on the State Board of Dental Examiners, for five years as its president. In 1951 Doctor Roberts received a "Citation for Achievement in Dentistry" from the University of Buffalo.

Awards for items submitted for this month's DENTISTS IN THE NEWS have been sent to:

Mrs. H. M. Saunders, 3839 Delta Avenue, Long Beach 10, California
Mrs. Dorothy Deane, 5237 North 5th Street, Philadelphia 20, Pennsylvania
J. H. Welch, Box 871, Los Angeles 44, California
Ruth Evelyn Banta, Box 892, Terre Haute, Indiana
G. B. Mitchell, D.D.S., 33 Linwood Avenue, Buffalo, New York
Mrs. John R. Morris, 3904 Delmont Street, Richmond 22, Virginia
Glad Lee, 1129 West 6th Street, Los Angeles 17, California
Louis L. Binder, D.D.S., 5237 North 5th Street, Philadelphia 20, Pennsylvania
Harriett B. Gruber, Box 129, Sac City, Iowa
Hugh E. Thomas, Route 3, Madisonville, Tennessee
Theodore Katz, D.D.S., 2802 Grand Concourse, Bronx 58, New York
M. B. Newman, D.D.S. 1410 Morris Avenue, New York 56, New York
Maurice Zackheim, D.D.S., 1065 Grant Street, Buffalo, New York
Mrs. Wilba A. Bailey, 5506 Winchester Street, National City, California
Betty Harris, 207 Porter Building, Fairmont, Minnesota
Arthur H. Labaree, 161 Eighty-ninth Avenue, Jamaica 2, New York

CAN YOU USE A DOLLAR?

To EVERY READER who contributes a newsworthy item, something unusual about a dentist, *which is published in Dentists in the News,* we will send promptly a crisp, new one-dollar bill. Every clipping must be taken from a newspaper and carry the name of the publication and the date line. Clippings submitted cannot be returned. When more than one copy of a clipping is submitted, the first one received will be used. Send all items to Dentists in the News, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.



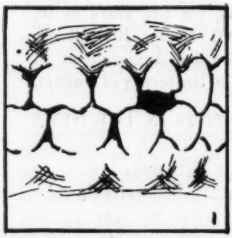
TECHNIQUE of the Month

Conducted by W. EARLE CRAIG, D.D.S.

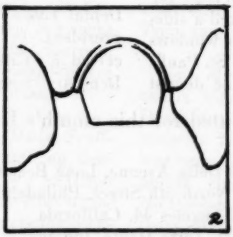
Drawings by Dorothy Sterling

Veneer Crown for Bicuspid

BY A. HAMILTON SIME, D.M.D.

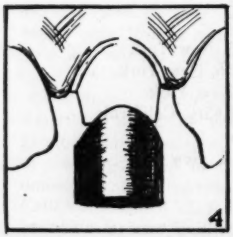


The case: Upper first bicuspid—vital, but fractured.

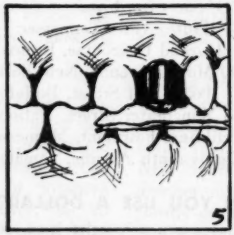


Taper the tooth and prepare the gingival ledge. Taper well on the buccal.

Take a wire measurement of preparation at the gingival and make a band of 22-30 gauge gold plate.



Fit the band well at the gingival and trim carefully so as to have plenty of clearance on the bite.



Soften inlay wax over the band and record the bite, using two thicknesses of rubber dam between the teeth when closing.

Carve the wax to shape and cut a depression on the labial of the wax to permit the insertion of plastic or silicate. Cast and polish. This method insures an accurately fitting crown.

Q ASK Oral Hygiene A

Please communicate directly with the department Editors, V. Clyde Smedley, D.D.S., and George R. Warner, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply.

Green and Black Stains

Q.—I have read your question and answer pages for over thirty years. This is my first letter to you. A number of my patients have green stains on their teeth. These stains, resulting from bacterial plaques, often cause caries. But the stain that I am often confronted with is a black stain that usually follows the gingival margin. This stain never causes caries, but returns shortly after a prophylaxis. Can you tell me the cause of this stain? Patients often ask me that question.—O. B. G., Kansas.

A.—Doctor Smedley has asked me to answer your letter in regard to green and black stains on the cervical margins of teeth.

What you say about green stains is true, and, as they occur in the mouths of children, the chromogenic bacteria find an especially favorable condition of the enamel to start caries.

In the past, we have attempted to control the deleterious effect of green stain by frequent prophylactic treatments; and with the cooperation of the patient, this plan has been reasonably successful. But a more effective method of controlling green stain was given to me by Doctor C. M. Stebner of Laramie, Wyoming: simply remove the stain and follow its removal with a Gottlieb treatment, using zinc chloride precipitated with potassium ferrocyanide. The stain does not recur thereafter, or at least not for a long time.

The black stain is an unsolved problem. In some cases, it seems to be related to certain elements in the diet. In one case, a heavy meat eater had the type of black stain of which you speak, but in other cases, the patient had the black stain despite the well-balanced diet.—GEORGE R. WARNER.

Partial Denture

Q.—Enclosed is a roentgenogram about which I should appreciate some advice.

I have removed all but the six anterior teeth in my patient's mouth. These I would have extracted also, but my patient's neighbors told him that the remaining teeth look good and to keep them. How long will a partial denture last—the cuspids are quite solid, but the incisors have little attachment? Will cuspids hold the partial denture for a few years?—P. F. O., Nebraska.

A.—In my opinion this man and his neighbors are right about the advisability of keeping these lower six anterior teeth.

How long a partial denture would last retaining these six teeth might depend on how the partial is constructed and serviced. Such a partial denture should be checked at regular intervals to determine

whether there is absorption under the saddles, throwing too much strain on the abutment teeth or too much occlusal stress on the upper anterior ridge. They should be rebased if and when this occurs.

A satisfactory way to make such a denture is to tie all six teeth into crib anchorage with three cast bars; lingual, Kennedy, and labial set below the cingulum with fingers extending upward to contact the incisors with bar rests to stabilize them and prevent them from drifting labially. A somewhat similar partial denture was shown in my office today that has been worn between twenty-five and thirty years.—V. CLYDE SMEDLEY.

Fractured Mandible

Q.—My patient, 60 years of age, fractured his mandible about three weeks before the enclosed roentgenograms were taken. It appears to be a fracture of the condyle, with displacement, and no sign of any union.

At present, his occlusion is normal, and the only pain he experiences is upon reclining his head and upon palpation. He can hear crepitation when moving his mandible into a certain position. He does not want his mandible to be wired closed for any length of time. There is no swelling or sign of infection present.

What would you recommend for this patient? If wiring is not done, what is your prognosis? Will the occlusion remain normal?—W. E. C., New York.

A.—Your letter describes the condition of the condylar fracture in the case of your 60-year-old man as shown by the good A. P. roentgenograms.

Considering that it is a diagonal fracture with definite separation between the ends, and subjective recognition of crepitus, there probably will be no repair of the fracture without fixation. It may be necessary to wire the fractured ends together, and to immobilize the fracture by wiring the mandible to the maxilla.

This is a most difficult case and should be handled by a skillful oral surgeon.—GEORGE R. WARNER.

Surgical Shock

Q.—I give local injections for almost all operative service. Will you please advise a procedure to follow in cases of shock, heart failure, and as an emergency measure when a physician is not available? Thank you.—E. A. I., Illinois.

A.—We find it wise to make a complete clinical and oral examination of every new patient, and in this examination we get the best history of general health conditions that we can elicit from the patient. We ask when he or she had his last physical examination, and if the heart, blood pressure, and kidneys were found to be all right. We also inquire into the question of allergies.

We think this plan is a safeguard against surgical shock or heart failure, for if in the case history there has been any report of disorder in the vital organs, we consult the family physician before using a local anesthetic for cavity preparation or surgery.

Any disturbance of the circulation, due to the anesthetic or mild surgical shock, is best treated by reclining the patient and having

Comb A MINK COAT?

rdly! The precious pelts must be cleaned with the greatest of care,
t their delicate beauty and integrity be irreparably marred. Dentures, too—
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cifications. Its divided tufts of fine bristles are individually wired-in
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VERNET'S PLATE BRUSH

him inhale aromatic spirits of ammonia. If the patient is not reviving fairly promptly, an intramuscular injection of 0.5 c.c. epinephrine hydrochloride solution can be used. We have never had to resort to this last suggested treatment.—GEORGE R. WARNER.

Fractured Incisor

Q.—Will you please tell me how to treat the following?

A 17-year-old patient of mine broke off the incisal edge of his upper, right, central four years ago. A crown would be the answer, although a drastic one. He has beautiful dentition. Could pins be cemented and then a restoration made using the brush technique, or would this require a metal backing for strength?

Thank you once again for your tremendous contributions to the solving of our problems.—C. G. M., Nevada.

A.—Your plan of treating your 17-year-old patient's fractured incisor is sound, and if he is reasonably careful, the acrylic corner will stand up well. We have similar acrylic corners which have been in place several years and the brush technique probably makes a stronger restoration than the old pressure technique. You may need pins for anchorage but you do not need a metal backing. —GEORGE R. WARNER.

Prophylaxis

Q.—We had a patient in our office recently who said she was advised never to have her teeth cleaned by a dentist or hygienist. The dentist who gave this advice has passed away.

I have spoken to several dentists about the matter and our opinion is that she was advised incorrectly. There are no gingival conditions present.—M. J. J., West Virginia.

A.—If there are deposits of any nature on the teeth, and particularly if they are subgingival, they should be removed by one professionally qualified for such a service. I can think of no possible harm to a patient resulting from a skillful prophylactic treatment. —GEORGE R. WARNER.

HOW OLD ARE YOUR PATIENTS?

(*Continued from page* 1071)

obvious and today's parents are likely prospects, because they are fitted through education to comprehend such information. Dentistry in 1953 has a better-than-ever story to tell these parents.

With such efforts bringing more youngsters more regularly to dental offices, one outstanding professional benefit would result. The average age of patients would be drawn closer to that desirable half-the-practitioner's-age, and the prospects for volume demand of dentists' time would be improved for years to come.

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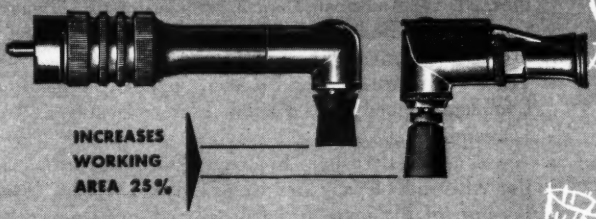

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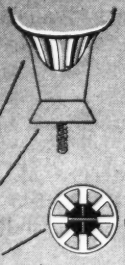

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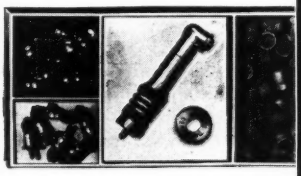

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SO YOU KNOW SOMETHING ABOUT DENTISTRY!

ANSWERS TO QUIZ CVII

(See page 1084 for questions)

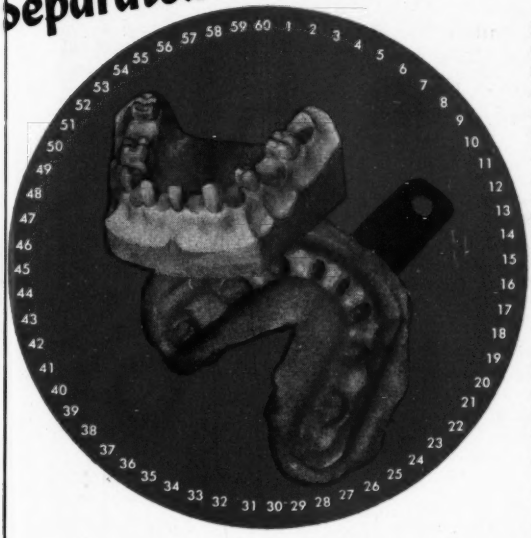
1. (a), (b). (Sicher, Harry: Oral Anatomy, St. Louis, C. V. Mosby Company, 1949, page 128)
2. The cellulosic acid inhibits epithelization. (Accepted Dental Remedies, ed. 17, American Dental Association, 1952, page 96)
3. (a) loss. (Schweitzer, J. M.: Oral Rehabilitation, St. Louis, C. V. Mosby Company, 1951, page 561)
4. True. (Standard, S. G.: Problems Related to the Construction of Complete Upper and Partial Lower Dentures, JADA **43**:699 [December] 1951)
5. (b) 4 or 5. (Bernstein, Emanual; and Neuworth, Isaac: Prescription Aids in Everyday Dentistry, JADA **43**:565 [November] 1951)
6. Because of the extreme hardness and brittleness, the blades will break if rotation is started with pressure on tooth substance. (Osborne, J.; Anderson, J. N.; and Lammie, G. A.: Brit. D. J. **90**:233 [May 1] 1951)
7. Yes—until nutrition is cut off secondarily by extension of the inflammatory process. (Blair, V. P.; and Ivy, R. H.: Essentials of Oral Surgery, ed. 4, St. Louis, C. V. Mosby Company, 1951, page 219)
8. True. (Goldman, H. M.: Periodontia, ed. 2, St. Louis, C. V. Mosby Company, 1949, page 69)
9. (a), (b), (c), (d), all. (Shepro, M. J.: Oral Manifestations of Metabolic Disturbances, JADA **43**:543 [November] 1951)
10. Yes. (McCormack, D. W.: Intraoral Roentgenology, D. DIGEST **57**:106 [March] 1951)

"THOSE GOOD OLD DAYS!"

LET US imagine that a person had a cavity in one of his teeth in the year 1905. He would go to a dentist who would make a whole project out of it. He would drag treatment over ten sittings, because you did not have the five dollars to pay him all in one shot. So you paid him fifty cents every time you came, and he cleaned out the old cotton, squirting some evil smelling chemical into the cavity, then put in a new change of cotton. Today's dentists call these old-time practitioners "the cotton brigade," but the poor people, and I know, because I was one of them, experienced terrific wear and tear on their nervous systems because of it.—*J. I. Rodale, Prevention Magazine.*

Taken on Friday!

Separated on Monday!



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LAFFODONTIA

Sarge: "I suppose when you get out of the Army you'll be waiting for me to die so you can spit on my grave."

Rookie: "No, sarge. After I shed this uniform, I never want to stand in line again."

★

An old New Englander was remarkably well informed, but so very lazy that the new pastor asked him how he had contrived to learn so much.

He replied: "I just heard it—here and there—and was too lazy to forget it."

★

Grandad arrived at the baseball game rather late, and was reprimanded by his grandson . . . "Why so late?" he asked; "it's the last of the fifth" . . . "Oh, never mind that," answered granddad, "I've brought an extra bottle."

★

"Thanks very much for the beautiful necktie," said Junior, kissing Grandma dutifully on the cheek.

"Oh, that's nothing to thank me for," she murmured.

"That's what I thought, but Ma said I had to."

★

"Thankful," grumbled the sourpuss to the sunshine spreader. "What have I got to be thankful for? Why I can't even pay my bills."

"In that case," prompted the other, "be thankful that you aren't one of your creditors."

★

The senator was covering a rural area seeking re-election. His long-winded address had been going on and on, punctuated only by occasional gulps of water. During one of these very brief pauses an old farmer turned to his neighbor and in a loud whisper observed, "First time I ever saw a windmill run by water."

★

Johnny: "My father's a doctor. I can be sick for nothing."

Jimmie: "Well, mine's a preacher—so I can be good for nothing."

★

"Johnny, how did you get that terrible lump on your head? Have you been fighting again?"

"No, Mamma, I haven't been fighting."

"Are you sure?"

"Sure. I wasn't fighting. It was an accident."

"An accident?"

"Yeah. I was sitting on Jimmy Jordan, and I forgot to hold his feet."

★

Bobby: "Dad, what are those holes in the board for?"

Dad: "Those are knot holes."

Bobby: "Well, if they are not holes, what are they?"

★

"My wife used to play the piano a lot, but since the children came she doesn't have the time."

"Children are a comfort, aren't they?"

★

A little mink died and went to heaven where St. Peter met him at the Pearly Gate.

"You were a good little mink on earth," said St. Peter, "so we'll give you anything you like in heaven. What do you want?"

"Well," said the little mink, "I think I'd like a coat made of little chorus girls."